STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225339	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Rehabilitation and Nursing Center	300 Winthrop Street Medford, MA 02155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure a home-like environment on the [NAME] unit. Specifically, the facility failed to 1a. ensure room [ROOM NUMBER]'s bathroom was cleaned thoroughly of urine residue and 1b. ensure the shower room was in good working condition.Findings include:The surveyor made the following observations:1a. On 7/29/25 at 9:51 A.M., there was a strong urine odor in the hallway near room [ROOM NUMBER]. Upon further observation, in room [ROOM NUMBER]'s bathroom, there was urine on the floor around the toilet, the floor was sticky, and the floor had a greenish color from the urine stain.On 7/30/25 at 6:37 A.M., there was a strong urine odor from room [ROOM NUMBER]'s bathroom, the floor was wet and sticky.On 7/30/25 at 1:14 P.M., room [ROOM NUMBER]'s bathroom floor was wet and sticky with a strong urine odor.During an interview on 7/30/25 at 2:12 P.M., Certified Nursing Assistant (CNA #4) said that the bathroom floor in room [ROOM NUMBER] is always wet and she cleans every time she sees it wet.During an interview on 7/30/25 at 2:19 P.M., Housekeeper #2 said she always cleans the bathroom in room [ROOM NUMBER] but can't seem to keep the floor dry.During an interview on 8/1/25 at 8:20 A.M., Housekeeper #1 said the residents' bathrooms are cleaned twice a day in the morning and in the afternoon. She said room [ROOM NUMBER]'s bathroom tiles may need to be removed as they are soaked with urine, and it makes it difficult to get rid of the urine odor.1b. On 7/29/25 at 8:47 A.M., in the [NAME] unit shower room, the surveyor observed a chipped toilet seat and the wall in the shower room had missing tiles. During an interview on 8/1/25 at 8:15 A.M., the Maintenance Director said the toilet seat should be replaced due to chipping, and the tiles should be replaced as they have been falling off the wall.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for two Residents (#13 and #15), out of 31 sampled residents. Specifically:For Resident #13 the facility failed to ensure the MDS assessment was accurately coded for significant weight gain (section K).For Resident #15 the facility failed to ensure the MDS assessment was accurately coded for the use of tobacco. Findings include:1.Resident #13 was admitted to the facility in November 2024 with diagnoses of mild cognitive impairment and psychotic disorder.Review of the most recent Minimum Data Set (MDS) assessment, dated 5/22/25, indicated the Resident scored a 13 out of 15 on the Brief Interview for Mental Status exam (BIMS) indicating the Resident was cognitively intact.Review of Resident #13's weights indicated the following:-On 1/7/25 the Resident weighed 99.5 lbs. (pounds).-On 2/14/25 the Resident weighed 122.2 lbs. which indicated a significant weight gain of 22.02% in one month.Review of the quarterly MDS dated [DATE] section K failed to indicate significant weight gain was coded.During an interview on 7/31/25 at 10:04 A.M., the Registered Dietitian said she should have coded significant weight gain on the quarterly MDS. 2. Resident #15 was admitted to the facility in May 2025 with diagnoses including nicotine dependence cigarettes.Review of the Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of a 15 on the Brief Interview for Mental Status exam (BIMS) indicating the Resident was cognitively intact.On 7/30/25 at 9:30 A.M., the surveyor observed Resident #15 sitting outside smoking, the Resident was wearing a smoking apron.Review of Resident #15's care plan date initiated 5/22/25: Resident is able to smoke with apron and with supervision.Review of the admission MDS dated [DATE] section J failed to indicate the use of tobacco.During an interview on 7/30/35 at 10:34 A.M., the MDS Nurse said she should have coded in the MDS section J that the Resident uses tobacco.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews, and records reviewed, the facility failed to meet professional standards of practice for 5 Residents (#106, #3, #82, #117, and #99) out of a total sample of 31 residents. Specifically: 1. For Resident #106, the facility failed to ensure nursing implemented physician orders for blood sugar checks and failed to administer medications as ordered.2. For Residents # 3, #82, #117, and #99, the facility failed to implement physician orders blood sugar checks and for insulin administration prior to the breakfast meal. Findings include:1. On 7/29/25 the following observations were made on the Pleasant View Unit:-At 7:31 A.M. , the surveyor observed Nurse #2 on the Pleasant View unit and there were no other nurses observed on the unit. Nurse #2 said he was the only nurse present on the unit at this time and had the keys to both medication carts. On 7/29/25 at 7:59 A.M., Resident #106 said he/she has not received morning medications and could not eat breakfast until the medications were given. The surveyor observed a breakfast tray on the Residents overbed table. The food items remained covered and untouched.-At 8:39 A.M., breakfast carts had arrived and all breakfast meal trays were delivered and set up was completed. Residents on the unit were observed eating breakfast in their rooms and in the dining room. -At 9:01 A.M., Nurse #2 said he has not given shift report or counted off his medication cart with any oncoming nurses yet and said Nurse #3 is helping with breakfast and will get report and count off the medication cart after breakfast.On 7/29/2025 at 9:10 A.M., Resident #106 said he/she still has not eaten breakfast and said she has yet to receive any morning medications. The surveyor observed a breakfast tray on the Resident's overbed table. The food items remained covered and untouched. Resident #106 told Certified Nursing Assistant (CNA) #2 that he/she can't eat until he/she has taken the morning medication.-At 9:27 A.M., the surveyor observed Nurse #4 at a medication cart. Nurse #4 said he was asked to come to the Pleasant View unit to help until the scheduled nurse arrived and said he has not administered any medications or obtained any blood sugars at this time.-At 9:28 A.M., Nurse #3 and Unit Manager #1 said they have not given any medications and have not taken any blood sugars. Nurse # 3 said she has residents who require blood sugar checks and required insulin before breakfast, but she did not get a shift report because the Unit Manager talked to the overnight Nurse #2. Unit Manager #1 said she was not given any blood sugar readings from the overnight nurse and said she does not know who needs blood sugar checks. The surveyor along with Nurse #3 and Unit Manager #1 looked at the Electronic Medical Records (EMAR) for Resident #106. Nurse #3 said Resident #106 has not received any morning medications and said the blood sugar check is not documented in the medical record. Nurse # 3 and Unit manager # 1 said they do not know his/her blood sugar level as it was not documented or reported. Unit Manager #1 said blood sugar levels were not reported from the overnight nurse and said they should be in the EMAR. Nurse #3 said she has not obtained any blood sugars or administered any medications to residents as she was assisting with the breakfast meal. -At 9:31 A.M., Nurse #2 said he has not given shift report or counted off his medication cart with any oncoming nurses yet and said the Unit Manager is going to take his cart.-At 9:40 A.M., Nurse #1 said she just arrived and has not obtained shift report or completed narcotic count on the medication cart. Nurse #1 said she has not obtained any blood sugars or administered any medications and was not given any blood sugar information.Resident #106 was admitted to the facility in March 2021 with diagnoses including type two diabetes, gastro-esophageal reflux disease, anxiety and dementia.Review of the Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident #106 had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15 which indicated moderately impaired cognition.Review of the active physician orders for Resident #106 indicated the following:-Check FSBS BID (fasting sugar blood sugar two times per day) and PRN (as needed) two times a day for DM2 (type two diabetes). Start Date: 5/27/25. Scheduled for 6:30 A.M., and 4:30 P.M.- Pepcid Oral Tablet 20 MG (milligrams) (Famotidine) Give 1 tablet by mouth two times a day for GERD (gastro esophageal reflux disease). Start Date: 9/23/23. Scheduled for 6:30 A.M., and 4:30 P.M.- Simethicone Oral Tablet Chewable 80 MG (Simethicone) Give 1 tablet by mouth before meals and at bedtime for bloating & gas distress. Start Date: 10/02/23. Scheduled for 6:30 A.M., 11:30 A.M., 4:30 P.M., 9:00 P.M.-Diazepam Tablet 5 MG Give 1 tablet by mouth three times a day for Muscle spasms. Start Date 7/25/25. Scheduled for 6:00 A.M., 2:00 P.M. , and 10:00 P.M.Review of Resident #106's July 2025 Medical Administration Record (MAR) indicated the following:-Check FSBS (Finger Stick Blood Sugar) BID contained no documentation and was not documented as completed.- Pepcid Oral Tablet 20 MG no documentation and was not documented as completed.- Simethicone Oral Tablet Chewable 80 MG no documentation and was not documented as

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that an assessment for self-administering medication was completed and that the second floor remained free of unattended and unsecured medications for one Resident (#11) out of a total sample of 31 Residents. Specifically, for Resident #11, the facility failed to ensure the Resident was assessed to self-administer an inhaler and ensure it was secured safely in the Resident's room.Findings include: Review of the facility policy titled Administering Medications, dated [DATE], indicated the following:Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safelyReview of the facility policy titled Medication, Self Administration, dated and revised [DATE], indicated the following:When a resident requests medication self-administration, initiate the process to assess resident's capability. The resident must meet the following criteria:Knowledge of medications and medication scheduleSelf-administration including packaging, reading label, opening containersAbility to administer medications properly, e.g. inhalers as neededSecure medications at the nursing station. Keep a limited quantity in a locked drawer at resident's bedside. Assure that resident and nursing both have a key. Instruct resident in medication self-administration procedure. Including:obtaining medication, administering medication according to physician order, recording administration on documentation record.Resident #11 was admitted to the facility in [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), unspecified dementia and anxiety disorder.Review of Resident #11's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident has a Brief Interview for Mental Status score of 4 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident has COPD or chronic lung disease.The surveyor made the following observations:- On [DATE] at 7:43 A.M., Resident #11 was using the bathroom in his/her room, on the Resident's bedside table was an inhaler that was not secured. No staff were present in the room. At 8:39 A.M., the inhaler was still on the bedside table, Resident #11 told the surveyor that he/she takes the inhaler when he/she needs it to breathe. Resident #11 then told the surveyor he/she is independent with everything and staff do not help him/her take the inhaler.- On [DATE] at 8:50 A.M., Resident #11 was using the bathroom in his/her room, in the middle of the Resident's bed was an inhaler that was not secured. No staff were present in the room.- On [DATE] at 7:41 A.M., Resident #11 was sitting up on his/her bed. Resident #11 told the surveyor that his/her inhaler was in his/her sweatshirt pocket, the Resident pulled the inhaler out of the right pocket of the sweatshirt to show the surveyor.Review of Resident #11's physician's orders failed to indicate an order for self-administering medications. Review of Resident #11's care plans failed to indicate a care plan to self-administer medications. Review of Resident #11's medical record failed to indicate that an assessment was completed allowing Resident #11 to self-administer medications such as inhalers and to store them in his/her room. During an interview on [DATE] at 9:11 A.M., Certified Nursing Assistant (CNA) #1 said Resident #11 is typically independent with most activities of daily living and he supports the resident as needed. CNA #1 then said he has noticed that at times, Resident #11 gets out of breath when completing tasks.During an interview on [DATE] at 9:20 A.M., Unit Manager #1 said Resident #11 is independent with ADLs and he/she needs to take his/her time with things due to his/her breathing. Unit Manager #1 said Resident #11 has an inhaler and when he/she needs to use it he/she will ask staff for it and staff need to supervise him/her when he/she uses it. Unit Manager #1 said Resident #11 is not assessed to self-administer medications including his/her inhalers and he/she should not have any inhalers at his/her bedside without staff present and she did not know the Resident had an inhaler in his/her room. Unit Manager #1 said inhalers expire every 28 days and if staff do not know that the Resident has an inhaler then they cannot monitor the expiration date. Unit Manager #1 said if the inhaler is expired it would not work as effectively if Resident #11 needs it.During an interview on [DATE] at 10:36 A.M. with the Director of Nursing (DON) and Corporate Nurse #1, the DON said if a resident requests to self-administer medication then the facility completes an assessment form for each medication and how to safely self-administer it. Once completed, the Nurse Practitioner or Medical Doctor would approve it and put in a physician's order for self-administering medications. The DON then said any medication at the bedside needs to be locked and secured so other residents do not have access to it. The surveyor and Corporate Nurse #1 reviewed Resident #11's medical record together and she said she could not locate an assessment for Resident #11

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and records reviewed, the facility failed to ensure it was free from a medication error rate of greater than 5% when one nurse observed made 4 errors out of 30 opportunities, resulting in a medication error rate of 13.33%. Those errors impacted one Resident (#4), out of four residents observed.Findings include: Review of the facility policy, Administering Medications, dated as revised April 2024, indicated:-Medications are administered in a safe and timely manner, and as prescribed.-Medications are administered in accordance with prescriber orders, including any required time frame.-Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).-Medications administration times are determined by resident need and benefit and as per MD order. Factors that are considered include:a. Enhancing optimal therapeutic effect of the medication;b. Preventing potential medication or food interactions; andc. Honoring resident choices and preferences, consistent with his or her care plan.-The individual administering medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. For Resident #4, the facility failed to ensure nursing administered medications as prescribed.Resident #4 was admitted to the facility in June 2024 with diagnoses of cognitive communication deficit, gastro esophageal reflux disease, anemia, and anxiety.On 7/30/25 at 10:15 A.M., the surveyor observed Nurse #5 administer medications to Resident #4 including: -One Baclofen Tablet Give 5 MG (milligram) tab (tablet).-Two Depakote Sprinkles Oral Delayed Release capsules. -One Furosemide Tablet 20 MG tablet.Review of the physician's orders indicated the following:-Baclofen Tablet Give 5 MG by mouth two times a day for Muscle spasms. Scheduled for 8:00 A.M., and 8:00 P.M. Start Date 5/25/25. -Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsules by mouth two times a day for Mood Disorder. Scheduled for 8:00 A.M., and 8:00 P.M. Start Date 3/28/25.-Furosemide Tablet 20 MG Give 0.5 tablet by mouth two times a day for BLE (bilateral lower extremity) Edema (swelling). Scheduled for 8:00 A.M., and 8:00 P.M. Start Date 5/6/25.The medications were administered more than two hours after they were scheduled at 8:00 A.M.During an interview on 7/30/25 at 9:42 A.M., Nurse #5 said he should have administered the medication at the correct ordered time or within one hour of the time they were due. During an interview on 7/30/24 at 2:01 P.M., Unit Manager #1 said nursing should follow the physician's order and administer medications within one hour before or after the scheduled time. During an interview on 7/31/24 at 1:15 P.M., the Director of Nurses said nursing should follow the physician's order and administer medications within one hour before or after the scheduled time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, the facility failed to ensure medication carts were locked while a nurse was not present on the Pleasant View Unit and ensure nursing staff secured medications in the medication cart prior to leaving the cart unattended during medication pass. Findings include: Review of the facility policy titled Storage of Medications, dated September 2018, indicated the following:-Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. On 7/30/24 at 10:11 A.M., the surveyor observed a medication cart unlocked and unsupervised on the Pleasant View unit. The Surveyor observed Nurse #5 walk away from the mediation cart and into a resident's room and stand behind a privacy curtain. The medication cart was unlocked, and the surveyor was able to open the medication cart and gain access inside. The unlocked medication cart and medications were left accessible and unattended in the hall, and one resident was observed near the medication cart and one housekeeping staff member was a short distance from the medication cart.During an interview on 7/30/25 at 10:18 A.M., Nurse #5 said he should not have left the medication cart unlocked and unattended. During an interview on 7/31/25 at 1:22 P.M., the Director of Nursing said medication and treatment carts must be locked when the nurse is not at the cart. 2. On 7/30/24 at 9:40 A.M., the surveyor observed Nurse #5 remove medications from the medication cart and placed them on top of the medication cart. The surveyor observed Nurse #5 open one box containing 2 medication packets on top of the medication cart, place the packets on top of the medication cart and walk into a resident's room. The nurse was not within sight line of the medication cart. The surveyor observed a resident and staff members walking by the unlocked medication cart.On 7/30/24 at 9:53 A.M., the surveyor observed Nurse #5 remove medications from the medication cart and placed them on top of the medication cart. The surveyor observed Nurse #5 open one box containing four medication packets on top of the medication cart, place the packets on top of the medication cart and walk into a resident's room behind a privacy curtain. The nurse was not within sight line of the medication cart. The surveyor observed a resident and staff members walking by the unlocked medication cart multiple times.During an interview on 7/30/25 at 10:20 A.M., Nurse #5 said he should not have left medications on top of the medication cart unattended and walked away and said medication must be stored and locked inside of the medication cart. During an interview on 7/31/25 at 1:24 P.M., the Director of Nursing said medication carts must be always locked when unattended and said medications should not be left on top of the medication cart or left unattended and must be stored properly.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record review, the facility failed to maintain accurate medical records for one Resident (#106), out of a total sample of 31 residents. Specifically, the facility failed to accurately document medication administration.Findings include: Resident #106 was admitted to the facility in March 2021 with diagnoses including type two diabetes, gastro-esophageal reflux disease, anxiety and dementia. Review of the Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident #106 had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15 which indicated moderately impaired cognition.On 7/29/25 at 7:59 A.M., Resident #106 said he/she has not received morning medications and could not eat breakfast until the medications were given. The surveyor observed a breakfast tray on the Resident's overbed table. The food items remained covered and untouched.Review of Resident #106's physician orders indicated: -Check FSBS BID (finger stick blood sugar two times per day) and PRN (as needed) two times a day for DM2 (type two diabetes). Start Date: 5/27/25. Scheduled for 6:30 A.M., and 4:30 P.M.- Pepcid Oral Tablet 20 MG (milligrams) (Famotidine) Give 1 tablet by mouth two times a day for GERD (gastro esophageal reflux disease). Start Date: 9/23/23. Scheduled for 6:30 A.M., and 4:30 P.M.- Simethicone Oral Tablet Chewable 80 MG (Simethicone) Give 1 tablet by mouth before meals and at bedtime for bloating & gas distress. Start Date: 10/02/23. Scheduled for 6:30 A.M., 11:30 A.M., 4:30 P.M., 9:00 P.M.-Diazepam Tablet 5 MG Give 1 tablet by mouth three times a day for Muscle spasms. Start Date 7/25/25. Scheduled for 6:00 A.M., 2:00 P.M., and 10:00 P.M. Review of Resident #106's July 2025 Medication Administration Record (MAR), failed to indicate Resident #106 was administered the medication as ordered by the physician and did not contain documentation of administration.During an interview on 7/29/25 at 9:01A.M., Nurse #2 said Resident #106 took all his/her morning medications and said he did not document them in the medical record. During an interview on 7/29/25 at 9:28 A.M., Unit Manager #1 reviewed the electronic medical record with the surveyor and said Resident #106 did not receive his/her morning medications and said she would expect the nurse to document when medications are administered in the medical record. Review of the administration history report provided by the facility indicated the physician order for FSBS BID, Pepcid Oral Tablet 20 MG., and Simethicone Oral Tablet Chewable 80 MG, was not documented as completed until 9:49 A.M. Diazepam Tablet 5 MG was not documented as completed until 9:30 A.M.During an interview on 7/29/25 at 10:35 A.M., Consulting Staff #1 said physician orders must be administered as ordered and documented in the medical record at the time of administration. During an interview on 7/30/25 at 1:14 P.M., the Director of Nurses (DON) said she expects orders to be followed and said she expects staff to obtain blood sugar levels and administer medications when they are ordered and to document at the time of administration.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to ensure nursing staff performed hand hygiene appropriately during the medication administration task. Findings include:Review of the Facility's Policy titled, Handwashing/Hand Hygiene, undated, indicated: -It is the expectation of the facility that all personnel wash their hands appropriately in accordance with current standards of practice.-Alcohol hand cleanser may be used as a hand cleansing agent unless hands are visibly soiled. -Hands are to be washed before and after patient contact.During medication administration pass on 7/30/25 the following were observed:-Nurse #5 at 9:40 A.M. was observed picking up keys to lock the medication cart and then placing two fingers inside a plastic cup of water to carry the cup into a resident room. -Nurse #5 at 9:41 A.M. was observed entering a resident room to administer medications and did not perform hand hygiene.-Nurse #5 at 9:43 A.M. was observed entering a resident room to administer medications, touched the bathroom door handle and did not perform hand hygiene.-Nurse #5 at 9:47 A.M. was observed removing a lidocaine patch from a resident's right shoulder without wearing gloves. The Nurse then exited the resident's room and did not perform hand hygiene During an interview on 7/30/25 at 9:51 A.M. , Nurse #5 acknowledged he should have performed hand hygiene prior to entering any resident room, should not have placed his fingers inside of the cup of water and said he should have worn gloves to remove the old lidocaine patch from the resident's shoulder and performed hand hygiene. During an interview on 7/31/25 at 1:22 P.M., the Director of Nurses (DON) said she expects staff to perform hand hygiene before entering a resident's room and said she expects staff to wear gloves when coming into contact with a resident. The DON said hand hygiene should be performed before and after glove use.